AmeriHealth Caritas Louisiana

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# Behavioral Health Psychiatric Residential Treatment Facility Referral Form

## Psychiatric residential treatment facility (PRTF) referral information

Date of referral:_____

Referral contact:_____ Referral facility/agency:_____

Phone number:_____ Fax number:_____

PRTF referrals made
Has the member been accepted at a PRTF? ❑ Yes ❑ No
If yes, please list actual facilities in the table below. If no, please list the potential facilities that the referring agency has identified as possible placements.

| PRFT name | Accepted | Not accepted | Awaiting decision | Is this facility recognized by Louisiana DHH? |
|---|---|---|---|---|
| | ❑ | ❑ | ❑ | ❑ Yes ❑ No |
| | ❑ | ❑ | ❑ | ❑ Yes ❑ No |
| | ❑ | ❑ | ❑ | ❑ Yes ❑ No |
| | ❑ | ❑ | ❑ | ❑ Yes ❑ No |
| | ❑ | ❑ | ❑ | ❑ Yes ❑ No |
| | ❑ | ❑ | ❑ | ❑ Yes ❑ No |
| | ❑ | ❑ | ❑ | ❑ Yes ❑ No |

Date of admission/potential admission to PRTF: _____

| **Demographic information (please print)** | | | |
|---|---|---|---|
| Child's name: | | ❑ Male ❑ Female | |
| Date of birth: | Age: | Ethnicity: | Primary language: |
| Current placement: | | Admission date: | |
| Social Security number: | | Medicaid ID number: | |
| Address: | | | |
| City: | | State: | Zip code: |
| Home phone number: | | | |

| **Emergency contact (other than primary caregiver)** | |
|---|---|
| Name: | |
| Relationship to child: | Languages: |
| Address: | |
| Home/cell phone: | Work phone: |

| **Legal guardian (if other than listed above)** | |
|---|---|
| Name: | |
| Relationship to child: | |
| Home/cell phone: | Work phone: |

| DCFS involvement (if applicable) | |
|---|---|
| DCFS supervisor: | Phone: |
| DCFS program supervisor: | Phone: |
| DCFS social worker area office: | Phone: |
| Reason and level of DCFS involvement: | |
| Client DCFS status: ❑ Child is in custody ❑ Investigation ❑ Other: | |

| Juvenile court involvement (if any) | |
|---|---|
| Probation officer: | Phone: |
| Is the member in OJJ custody?: ❑ Yes ❑ No | |

| Arrest history | | | |
|---|---|---|---|
| **Criminal charge** | **When** | **Where** | **Disposition** |
| | | | |
| | | | |
| | | | |
| | | | |

| **Current family situation** |
| --- |
| Living situation (name/legal/relationship to member): |
| Family history, family psychiatric and substance abuse history, domestic violence, current family stressors that may be affecting patient: |
| Family's role in treatment: |
| Family's strengths: |
| Child's strengths: |
| Religious/cultural background: |
| Restrictions/special needs based on religious/cultural background or physical needs (if any): |

| Secondary insurance information (if any) | |
|---|---|
| Name of secondary insurance carrier: | |
| Insurance number: | Plan code number: |
| Subscriber: | Date of birth: |
| Subscriber's employer: | Relationship to insured: |
| Insurance verified: ❑ Yes ❑ No | |

| Psychiatric clinical information |
|---|
| What is the main clinical need or focal problem that leads you to request admission to a PRTF? |
| What are the contributing factors to the main clinical need/focal problem? Please consider factors from multiple life domains, including the individual, family, peer, school and community: |
| What are the goals for the PRTF stay and the recommended interventions corresponding to the contributing factors stated above? |

| Current diagnosis |
|---|
| DSM-5 diagnoses (include mental health, substance abuse and medical): |

**Current psychiatric medications and dosages**

| Name of drug/ symptoms behaviors | Dose | Schedule | Prescribing MD | Target |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| Were any medications discontinued due to adverse reactions? If so, which? | | | | |

| Has the child experienced any of the following? (please check one response) | | | | |
|---|---|---|---|---|
| **Symptom/behavior/diagnosis** | **Current** | **Past** | **Unknown** | **N/A** |
| Aggressive behavior | ❑ | ❑ | ❑ | ❑ |
| Anxiety/panic attacks | ❑ | ❑ | ❑ | ❑ |
| Attention deficit disorder | ❑ | ❑ | ❑ | ❑ |
| Depression | ❑ | ❑ | ❑ | ❑ |
| Dissociative features | ❑ | ❑ | ❑ | ❑ |
| Eating patterns/concerns | ❑ | ❑ | ❑ | ❑ |
| Fire setting | ❑ | ❑ | ❑ | ❑ |
| Hallucinations — auditory | ❑ | ❑ | ❑ | ❑ |
| Hallucinations — visual | ❑ | ❑ | ❑ | ❑ |
| History of cruelty to animals | ❑ | ❑ | ❑ | ❑ |
| Impulsive behavior | ❑ | ❑ | ❑ | ❑ |
| Juvenile court involvement | ❑ | ❑ | ❑ | ❑ |
| Oppositional behavior | ❑ | ❑ | ❑ | ❑ |
| Runaway | ❑ | ❑ | ❑ | ❑ |
| Substance use | ❑ | ❑ | ❑ | ❑ |
| Self-injurious behavior | ❑ | ❑ | ❑ | ❑ |
| Sexualized behavior | ❑ | ❑ | ❑ | ❑ |
| School problems | ❑ | ❑ | ❑ | ❑ |
| Sleep problems | ❑ | ❑ | ❑ | ❑ |
| Suicidal attempts | ❑ | ❑ | ❑ | ❑ |
| Suicidal ideation | ❑ | ❑ | ❑ | ❑ |

Trauma history/abuse: ❑ Yes ❑ No ❑ Unknown
If yes, please explain when and by whom and if member has received any treatment:

| Medical information | |
|---|---|
| Primary care physician: | Phone: |
| Allergies? | |

Check all that apply:

| | | |
|---|---|---|
| ❒ Asthma | ❒ Diabetes | ❒ Head trauma |
| ❒ Birth complications | ❒ GI disease | ❒ Seizures |
| ❒ Cardiac | ❒ HIV/AIDS | ❒ Thyroid disease |

Medical issues — significant medical history, hospitalizations or surgeries:

| Recent Test | Date | Abnormalities Y/N? | Explain |
|---|---|---|---|
| EKG | | ❑ Yes ❑ No | |
| EEG | | ❑ Yes ❑ No | |
| CT scan | | ❑ Yes ❑ No | |
| MRI | | ❑ Yes ❑ No | |
| Other | | ❑ Yes ❑ No | |

Identify any potential risk factors that may interact with medications:

| Current medical medications: | | | | |
|---|---|---|---|---|
| **Name of drug** | **Dose** | **Schedule** | **Prescribing MD** | **Test symptoms/ behaviors** |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| Any medical conditions that might impact use of restraint? | | | | |

| Educational information | |
|---|---|
| Child's current grade level: | Current school: |
| Special education classification? ❑ Yes ❑ No | Testing date: |
| Scores: | Current IEP date: |
| Academic, behavioral and social functioning in school. Note any suspensions: | |

| Treatment history and plan | | |
|---|---|---|
| **Has child ever received any of the following services?** | **Yes/No/Unknown** | **Where?** |
| Psychiatric hospitalization | ❑ Yes ❑ No ❑ Unknown | |
| Substance abuse treatment | ❑ Yes ❑ No ❑ Unknown | |
| CPST services | ❑ Yes ❑ No ❑ Unknown | |
| CSoC waiver | ❑ Yes ❑ No ❑ Unknown | |
| Outpatient treatment | ❑ Yes ❑ No ❑ Unknown | |
| Partial hospitalization | ❑ Yes ❑ No ❑ Unknown | |
| Residential treatment center | ❑ Yes ❑ No ❑ Unknown | |
| Psych-sexual evaluation | ❑ Yes ❑ No ❑ Unknown | |
| Psychological testing | ❑ Yes ❑ No ❑ Unknown | |
| Neuro-psych testing | ❑ Yes ❑ No ❑ Unknown | |
| Other waiver services | ❑ Yes ❑ No ❑ Unknown | |
| Other | ❑ Yes ❑ No ❑ Unknown | |
| Other | ❑ Yes ❑ No ❑ Unknown | |
| Other | ❑ Yes ❑ No ❑ Unknown | |
| Other | ❑ Yes ❑ No ❑ Unknown | |

| **What is the long-term disposition plan for this child?** | **What is the child's future vision for the long-term disposition plan?** |
|---|---|
| ❒ Reunification (if so, with whom?):_____ | ❒ Reunification (if so, with whom?):_____ |
| ❒ Therapeutic foster care | ❒ Therapeutic foster care |
| ❒ Residential treatment: | ❒ Residential treatment: |
| ❒ Group home:_____ | ❒ Group home:_____ |
| ❒ Other:_____ | ❒ Other:_____ |

| Current service providers | | | | |
|---|---|---|---|---|
| **Contact name** | **Agency** | **Phone** | **Services provided** | **Date of participation** |
| | | | | |
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| Does the child require a single room? If yes, state reason: | | | | |
| Previous experience with roommates: | | | | |

| Substance use disorder ASAM dimensions | | | | |
|---|---|---|---|---|
| **Dimension rating (0 – 4)** | **Current ASAM dimensions are required** | | | |
| Dimension 1: Acute intoxication and/or withdrawal potential<br>Rating: | Substances used (pattern, route, last used): | Tox screen completed?<br>❑ Yes ❑ No<br>If yes, results: | History of withdrawal symptoms: | Current withdrawal symptoms: |
| Dimension 2: Biomedical conditions and complications<br>Rating: | Vital signs: | Is member under doctor care?<br>❑ Yes ❑ No<br>Current medical conditions: | History of seizures?<br>❑ Yes ❑ No | |
| Dimension 3: Emotional, behavioral or cognitive conditions and complications<br>Rating: | MH diagnosis: | Cognitive limits?<br>❑ Yes ❑ No | Psych medications and dosages: | Current risk factors (SI, HI, psychotic symptoms, etc.): |
| Dimension 4: Readiness to change<br>Rating: | Awareness/ commitment to change: | Internal or external motivation: | Stage of change, if known: | Legal problems/ probation officer: |

| **Substance use disorder ASAM dimensions** | | | | |
|---|---|---|---|---|
| Dimension 5: Relapse, continued use or continued problem potential<br>Rating: | Relapse prevention skills: | Current assessed relapse risk level:<br>❑ High<br>❑ Moderate<br>❑ Low | Longest period of sobriety: | |
| Dimension 6: Recovery/living environment<br>Rating: | Living situation: | Sober support system: | Attendance at support group: | Issues that impede recovery: |

**Criteria section**

Is the child/adolescent expected to: (check one)

❒ Potential for improvement in symptoms/behavior with treatment

❒ Treatment expected to maintain symptoms/behavior without further deterioration

Over the last week has the child/adolescent had any of the following behaviors? (check all that apply)

❒ Fire setting

❒ Self-mutilation

❒ Runaway for more than 24 hours

❒ Daredevil/impulsive behavior

❒ Sexually inappropriate/aggressive/abusive

❒ Angry outburst/aggression unmanageable

❒ Positive psychotic symptoms unmanageable

❒ Hypomanic symptoms/increasing unmanageable

❒ Arrest/confirmed/illegal activity

❒ Persistent violation of court order

Has the child/adolescent's behaviors been present at least six months? ❑ Yes ❑ No
Are the child/adolescent's behaviors expected to persist longer than one year without treatment? ❑ Yes ❑ No

Has child/adolescent had any of the following unsucessful treatments within the past year? (check all that apply)

❒ Treatment foster care

❒ Residential treatment center/therapeutic group home

❒ At least three psychiatric inpatient admissions

❒ At least three psychiatric partial hospital admissions

❒ At least four psychiatric admissions to inpatient/partial hospital/inpatient/outpatient in any combination

Are the child/adolescent's behaviors unable to be managed safely in a lesser level of care? ❑ Yes ❑ No
Is the child/adolescent's support system: (check any of the following):

❒ Unavailable

❒ Unable to ensure safety

❒ High-risk environment

❒ Abusive

❒ Intentional sabotage of treatment

❒ Unable to manage intensity of symptoms

**Criteria section**

Does the child/adolescent have any of the following functioning problems? (check all that apply)

- ❒ Unable/unwilling to follow instructions/ negotiate needs
- ❒ Socially withdrawn
- ❒ Unable/unwilling to perform ADL
- ❒ Behavioral control for more than 48 hours and improvement is not expected within next two weeks

Signature and title of referring person:_____ Date:_____

**Supporting documentation required with packet:**

- Court order for placement (if one exists).
- Most recent psychiatric evaluation recommending PRTF placement in order to complete the Certification of Need (CON).
- Most recent clinical update, including diagnosis and medications.
- Most recent IEP.
- Clinical justification: If the member has not had extensive OP services, please get clinical justification why the member needs to be placed in a PRTF as opposed to starting more intensive OP services.

Facilities may require additional documentation/information prior to approval/decision.



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